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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13768

CERTIFICATE OF DEATH

Reg. Dist. No.

13741

1. PLACE OF DEATH a. COUNTY Harford		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harve de Grace		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First William	Middle Evans	Last Baker
4. DATE OF DEATH	Month Dec. 26,	Day 19	Year 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 17, 1869
9. AGE (In years lost birthday) 90 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Foreman. Penna. R.R.	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Goodwin	14. MOTHER'S MAIDEN NAME Baker	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 17. INFORMANT Eliza Lamar
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO <i>Chronic Hypochondriasis</i> <i>Chronic Appendicitis</i>		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Arterio - Sclerosis</i> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arterio - Sclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 17, 1959 to Dec. 26, 1959 , that I last saw the deceased alive on Dec. 16, 1959 , and that death occurred at 3 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Clarence I. Benson, M.D.</i>	ADDRESS (Street, city or town, state) Post Office, Perryville, Md.		
PHYSICIAN'S NAME (Type) Clarence I. Benson, M.D.	DATE SIGNED Dec. 26, 1959		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-30-1959	22c. NAME OF CEMETERY OR CEMINATORY Principio Cemetery	22d. LOCATION (City, town, or county) (State) Principio Furnace, Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>See a. Patterson & Son</i>	ADDRESS Perryville, Md.	24a. REC'D BY REGISTRAR DEC 30 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13769

CERTIFICATE OF DEATH

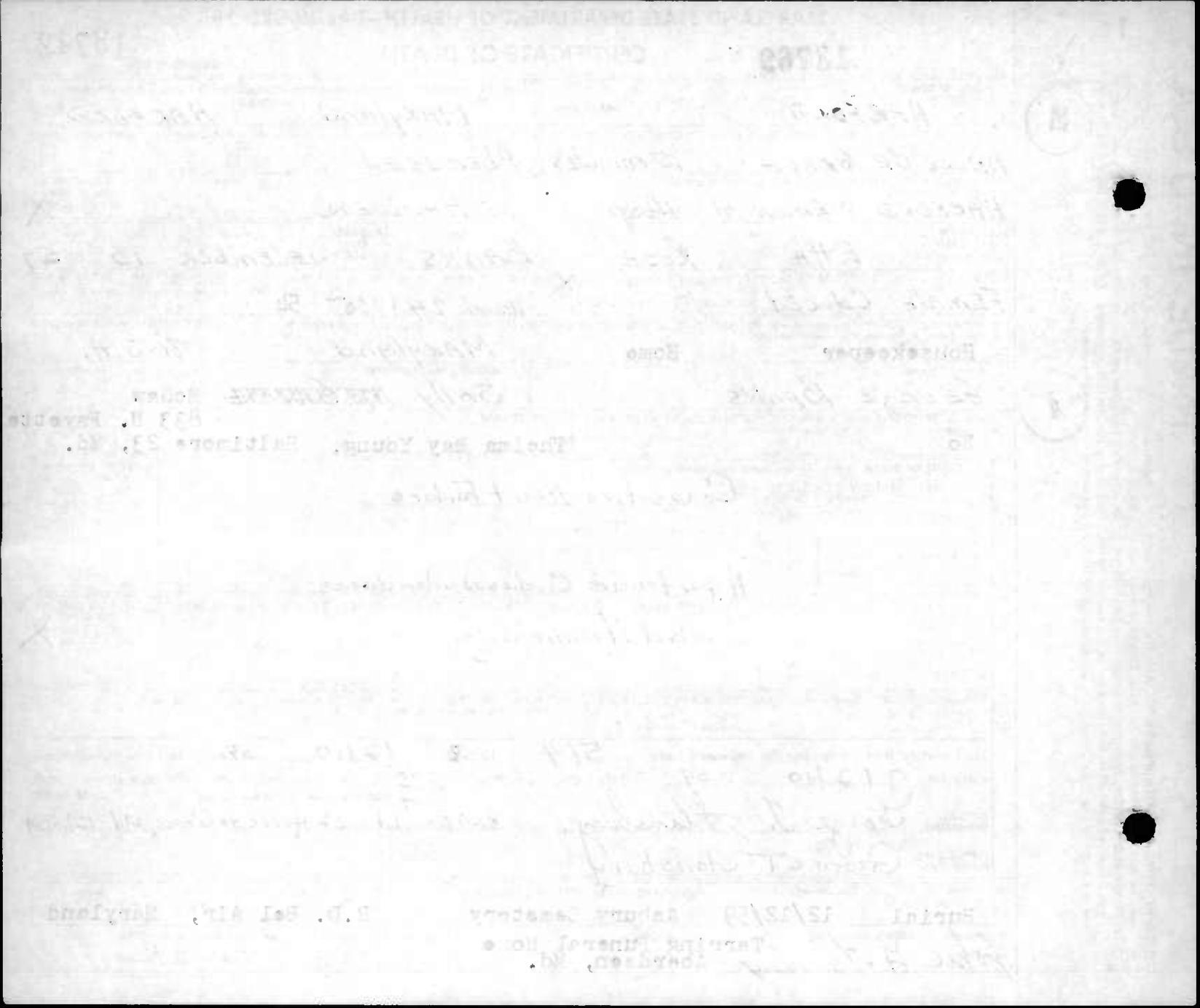
Reg. Dist. No.

13742

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY HARFORD		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARFORD GRACE		c. LENGTH OF STAY IN 1b 15 minutes	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSP.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ABERDEEN	
d. STREET ADDRESS 15 HANOVER		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ETA	Middle ROSE	Last BANKS
4. DATE OF DEATH DECEMBER 10 1959	Month	Day	Year
5. SEX FEMALE	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 24, 1905
9. AGE (In years lost birthday) 54	10. IF UNDER 1 YEAR Months 54	11. IF UNDER 24 HRS. Days 54	12. Hours 54
13. FATHER'S NAME GEORGE BANKS	14. MOTHER'S MAIDEN NAME SALLY McGRAW		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	INFORMANT Thelma May Young	Address 833 N. Fayette
17. CITIZEN OF WHAT COUNTRY? U.S.A.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure			
DUE TO 443X			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)			
DUE TO (c) Hyperensive Cardiovascular disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Hemorrhage			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 514	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 514 , 1959, to 12/10 , 1959, that I last saw the deceased alive on 12/10 , 1959, and that death occurred at 555 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE George J. Stansbury, M.D.		ADDRESS (Street, city or town, state) 569 Revolution St. Havre de Grace, Md. 12/10/59	
PHYSICIAN'S NAME (Type) George J. Stansbury		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/12/59	
22c. NAME OF CEMETERY OR CREMATORIAL Asbury Cemetery		22d. LOCATION (City, town, or county) (State) R.D. Bel Air, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Tanning		ADDRESS Tanning Funeral Home Aberdeen, Md.	
24a. REC'D BY REGISTRAR DATE DEC 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13784

CERTIFICATE OF DEATH

Reg. Dist. No.

13743

1. PLACE OF DEATH a. COUNTY Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Harford													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Forest Hill		c. LENGTH OF STAY IN lb 35 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Forest Hill		d. STREET ADDRESS Walters Mill Road													
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Walters Mill Road						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
3. NAME OF DECEASED (Type or print) Blanche		First B.	Middle Bedsaul	Last December 8	Month 19 59	Day	Year												
4. DATE OF DEATH December 8		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH June 10, 1903		9. AGE (In years lost birthday) 56 yrs.		10. IF UNDER 1 YEAR Months 5		11. IF UNDER 24 HRS. Days 6		12. IF UNDER 24 HRS. Hours 7		13. CITIZEN OF WHAT COUNTRY? U.S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home maker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 33IX		16. SOCIAL SECURITY NO. 214-30-7221		17. INFORMANT William M. Bedsaul, Rd. Box 307, Forest Hill, Mo.		Address R.D. #7					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive cerebral hemorrhage		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b)		DUE TO (c) Cerebral arteriosclerosis ?								INTERVAL BETWEEN ONSET AND DEATH 11 hours					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Forest Hill, Maryland		(County) Harford		(State) Maryland									
21. I certify that I attended the deceased from October 1929 to December 8, 1959 , that I last saw the deceased alive on December 7, 1959 , and that death occurred at 6:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forest Hill, Maryland DATE SIGNED Willard P. Hudson, M.D. December 8, 1959																			
ACTUAL SIGNATURE Willard P. Hudson		PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.																	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/10/59		22c. NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens		22d. LOCATION (City, town, or county) Bel Air, Maryland		(State) Maryland											
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Foster, Bel Air, Md.		ADDRESS		24a. REC'D BY REGISTRAR DEC 11 '59		24b. REGISTRAR'S SIGNATURE Charles E. Hudson													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH	TIME OF DEATH	PLACE OF DEATH	NAME OF DOCTOR	NAME OF HOSPITAL	NAME OF FUNERAL DIRECTOR
John Doe	50	Male	Heart Disease	10:00 AM	Hospital	Dr. Smith	General Hospital	Funeral Home
DEATH CERTIFICATE								
This certificate is issued to certify that the above named person died on the date and place indicated above.								
I declare under penalty of perjury that the information contained in this certificate is true and correct.								
Signed: _____								
Date: _____								

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 9,9,14 FILED 253 12-29-59 et

13744

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

o. COUNTY

Hartford

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hause de Grace

c. LENGTH OF STAY IN 1b

45 days

d. NAME OF HOSPITAL (If not in hospital, give street address)

OR INSTITUTION

Hartford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

o. STATE

Md

b. COUNTY

Hartford

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

24 Hause de Grace

d. STREET ADDRESS

628 N. Adams St.

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First
BARBARA

Middle

Last
BRADFIELD4. DATE
OF
DEATHMonth
DecemberDay
13Year
1959

5. SEX

6. COLOR OR RACE

Female

White

WIDOWED DIVORCED 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH
?-?-18689. AGE (In years
last birthday)
91

yrs.

10. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)11. BIRTHPLACE (State or foreign country)
Md12. CITIZEN OF WHAT COUNTRY?
U.S.

13. FATHER'S NAME

Michael Hutchinson

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

16. SOCIAL SECURITY NO.

INFORMANT

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

572.2

DUE TO

Peritonitis

INTERVAL BETWEEN
ONSET AND DEATH

24 hours

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

Rupture sigmoid colon

24 hours

DUE TO

(c)

Ulcerative colitis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m.20d. INJURY OCCURRED
While Not while
at work at work 20e. PLACE OF INJURY (Name, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from October 29, 1959, to December 13, 1959, that I last saw the deceased
alive on December 12, 1959, and that death occurred at 11:30 A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATUREPHYSICIAN'S
NAME (Type)22a. BURIAL, CREMATION,
REMOVAL (Specify) 22b. DATE THEREOF
12/15/59 22c. NAME OF CEMETERY OR CREMATORIUM
Angel Dell

22d. LOCATION (City, town, or county)

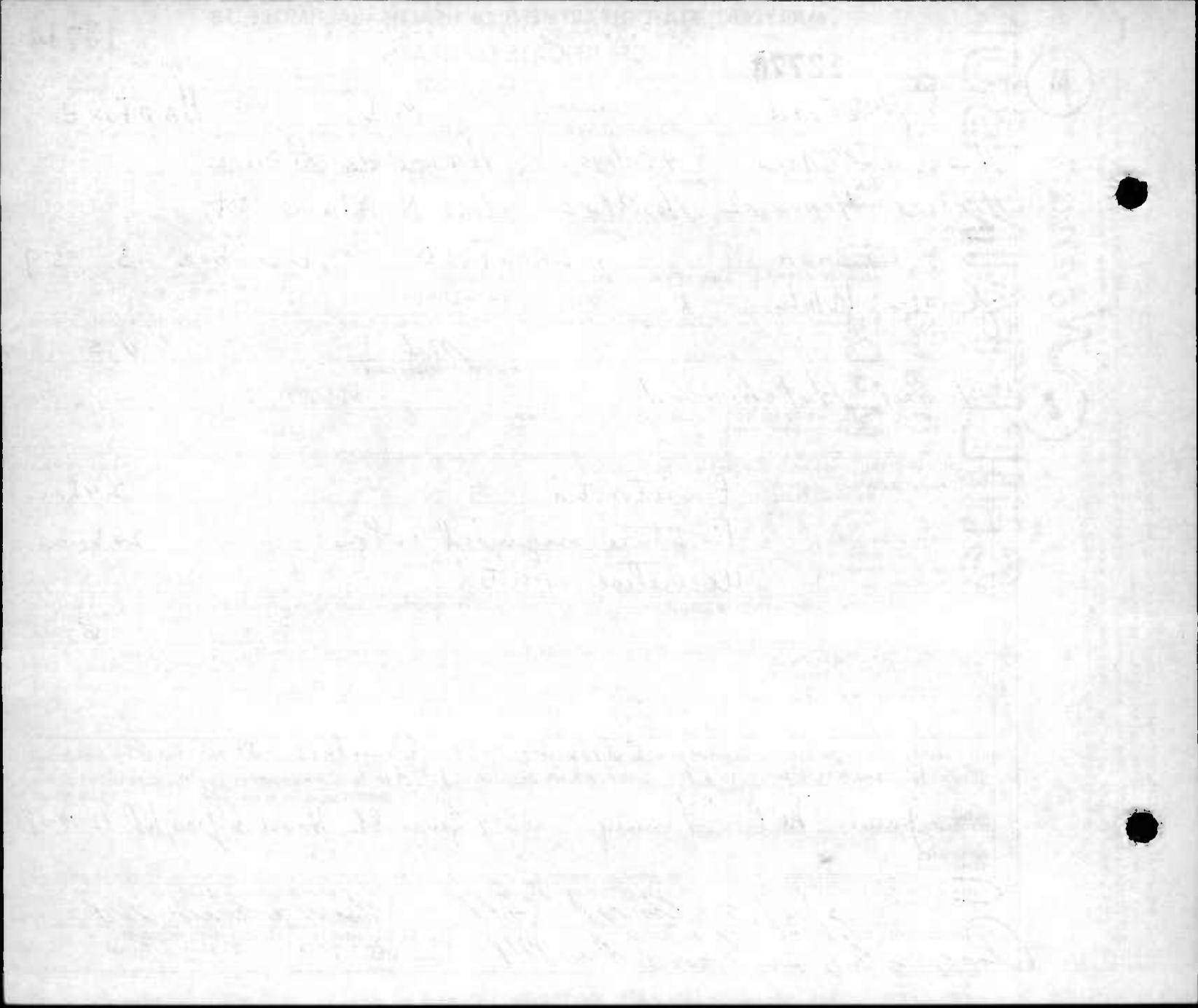
(State)

Hause de Grace Md

23. FUNERAL DIRECTOR'S SIGNATURE
Pamela L. Smith, Hause de Grace Md

ADDRESS

24a. REC'D BY REGISTRAR
DATE
DEC 17 '5924b. REGISTRAR'S SIGNATURE
Adams S. Hause



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13771

CERTIFICATE OF DEATH

Reg. Dist. No.

13745

1. PLACE OF DEATH a. COUNTY <i>Hanford</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hanford Grace</i>		c. LENGTH OF STAY IN 1b <i>49 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Carmina Cianelli</i>		First <i>Carmina</i>	Middle <i>Cianelli</i>
4. DATE OF DEATH <i>12/21/59</i>		Month <i>12</i>	Day <i>21</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Oct. 3, 1878</i>		9. AGE (In years, months, days, birthday) <i>81 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>
10b. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY <i>House Wife</i>		11. BIRTHPLACE (State or foreign country) <i>Italy</i>	11. IF UNDER 24 HRS. Days <i>0</i>
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Theresa Hanell, Hanford Grace, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypostatic Pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) <i>Cardiac decompensation</i>		<i>Arterios clavicular heart disease</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>12/20</i> , 19 <i>59</i> , to <i>12/21</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>12/21</i> , 19 <i>59</i> , and that death occurred at <i>70</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Charm H. Wallenpus, 407 S. Union, Hanford Grace, Md.</i>			
ACTUAL SIGNATURE <i>Charm H. Wallenpus</i>		DATE SIGNED <i>12/24/59</i>	
PHYSICIAN'S NAME (Type) <i>—</i>			
22a. CERIAL OR CREMATION, REMOVAL (Specify) <i>12/24/59</i>		22b. DATE THEREOF <i>12/24/59</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Calm</i>		22d. LOCATION (City, town, or county) <i>Hanford Grace, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Washington P. M. Hanford Grace, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 29 '59</i>	
ADDRESS <i>—</i>		24b. REGISTRAR'S SIGNATURE <i>C. C. H. 8. H. Hanford Grace, Md.</i>	

WISCONSIN STATE DEPARTMENT OF HEALTH - ALUMINUM

CERTIFICATE OF DEATH

DEATH CERTIFICATE

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13746

Reg. Dist. No.

13772

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		
4 Harford Maryland	a. STATE	b. COUNTY	Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
Harford	Eckton 07x.2		
c. LENGTH OF STAY IN 1b	d. STREET ADDRESS		
1 hour	RD 1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Harford Memorial Hospital			
3. NAME OF DECEASED (Type or print)	First	Middle	4. DATE OF DEATH
Charles Stanton Dailey			Month Day Year
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10/24/1929
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mgr.	Finance Co.	Grand Rapids Mich.	U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Henry J. Dailey	Maye Davis		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
W W 2	Unknown	May J. Dailey	1001 Academy Lane, Willow Run, Wilm. Del.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Fracture skull		
816X	DUE TO		
Conditions, if any, which gave rise to immediate cause (b)			
(a), stating the underlying cause last.	DUE TO		
	(c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
Fracture L. femur			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
	Anti accident		
20c. TIME OF INJURY Month, Day, Year Hour	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
1205 a.m. 12-9 '59	Rte 40 & 152		Harford Maryland
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> B. A. Palmer, M.D. DATE SIGNED		
EXAMINER'S NAME (Type)	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL OR CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL	22d. LOCATION (City, town, or county) (State)
	12-14-59	Arlington Md.	F. Meyer Va.
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
J. Wm. Lee & Sons	300 1/4 St N.E.	DEC 11 '59	Arthur S. Kraus

BY EMMERICH H. JAHN TO THE DIRECTOR OF THE NATIONAL
HISTORICAL PARKS AND MONUMENTS, WASHINGTON, D. C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13785

CERTIFICATE OF DEATH

Reg. Dist. No. 13747

1. PLACE OF DEATH a. COUNTY Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Bel Air		c. LENGTH OF STAY IN lb 19 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 32 Bel Air		d. STREET ADDRESS Rock Spring Avenue		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Convalescent Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Mary		First Frances	Middle Daughton	Last Daughton	4. DATE OF DEATH December	Month 24	Day 19	Year 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 28, 1888	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Practical		11. BIRTHPLACE (State or foreign country) Harford Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Henrey Daughton		14. MOTHER'S MAIDEN NAME Katherine N. Kelly						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-28-3185		17. INFORMANT Mrs. George E. Geyer		3115 Abell Ave. Balto. 18, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, terminating						INTERVAL BETWEEN ONSET AND DEATH ? <input type="checkbox"/>		
442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		Chr. cardiovascular-renal disease						
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Forest Hill, Maryland	(County)	(State)	
21. I certify that I attended the deceased from Nov. 1958 , 19, to December 24, 1959 , that I last saw the deceased alive on Dec. 23, 1959 , and that death occurred at 9:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forest Hill, Maryland DATE SIGNED Dec. 26, 1959								
ACTUAL SIGNATURE Willard P. Hudson M.D. Willard P. Hudson, M.D.								
PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.		22b. DATE THEREOF 12/28/1959		22c. NAME OF CEMETERY OR CREMATORIUM Jarrettsville		22d. LOCATION (City, town, or county) Jarrettsville, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22d. LOCATION (City, town, or county) Jarrettsville, Maryland		24a. REC'D BY REGISTRAR DATE DEC 29 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Kuhn		ADDRESS Jarrettsville, Maryland						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1939

NAME

ADDRESS

CITY

STATE

ZIP

NAME

ADDRESS

CITY

STATE

ZIP

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13786

CERTIFICATE OF DEATH

Reg. Dist. No.

13748

1. PLACE OF DEATH a. COUNTY HARFORD		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (RURAL) ROCKS		c. LENGTH OF STAY IN 1b 5 mos		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt 24		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UPPER FALLS		d. STREET ADDRESS BRADSHAW Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DAVID		First	Middle	Last	4. DATE OF DEATH DECEMBER 9 1959	Month	Day	Year	
5. SEX MALE		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 18, 1879		9. AGE (In years last birthday) 80 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WARD		10b. KIND OF BUSINESS OR INDUSTRY Tool Makers		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME DAVID DAVIDSON		14. MOTHER'S MAIDEN NAME REBECCA ROZETTE							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 216-10-1329A		17. INFORMANT MRS. HELEN SMITH, BEL AIR, MD.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1		DUE TO CORONARY		INTERVAL BETWEEN ONSET AND DEATH 30 MIN					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO CONGESTIVE HEART FAILURE		3WKS					
(c) DUE TO ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE		OVER 1YR							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DIABETES SENILITY.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from July 6 1959 to Dec. 9 1959 that I last saw the deceased alive on Dec. 9 1959 , and that death occurred at 11:30 AM from the causes and on the date stated above. ACTUAL SIGNATURE Philip W. Heuman M.D. ADDRESS (Street, city or town, state) 307 HICKORY DATE SIGNED DEC 9 1959									
PHYSICIAN'S NAME (Type) PHILIP W. HEUMAN M.D. BEL-AIR, MD									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-12-1959		22c. NAME OF CEMETERY OR CREMATORIAL Salem Methodist		22d. LOCATION (City, town, or county) Upper Falls, Beltsville, Md. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Lawhman Funeral Home		ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR DATE DEC 11 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Trahan			

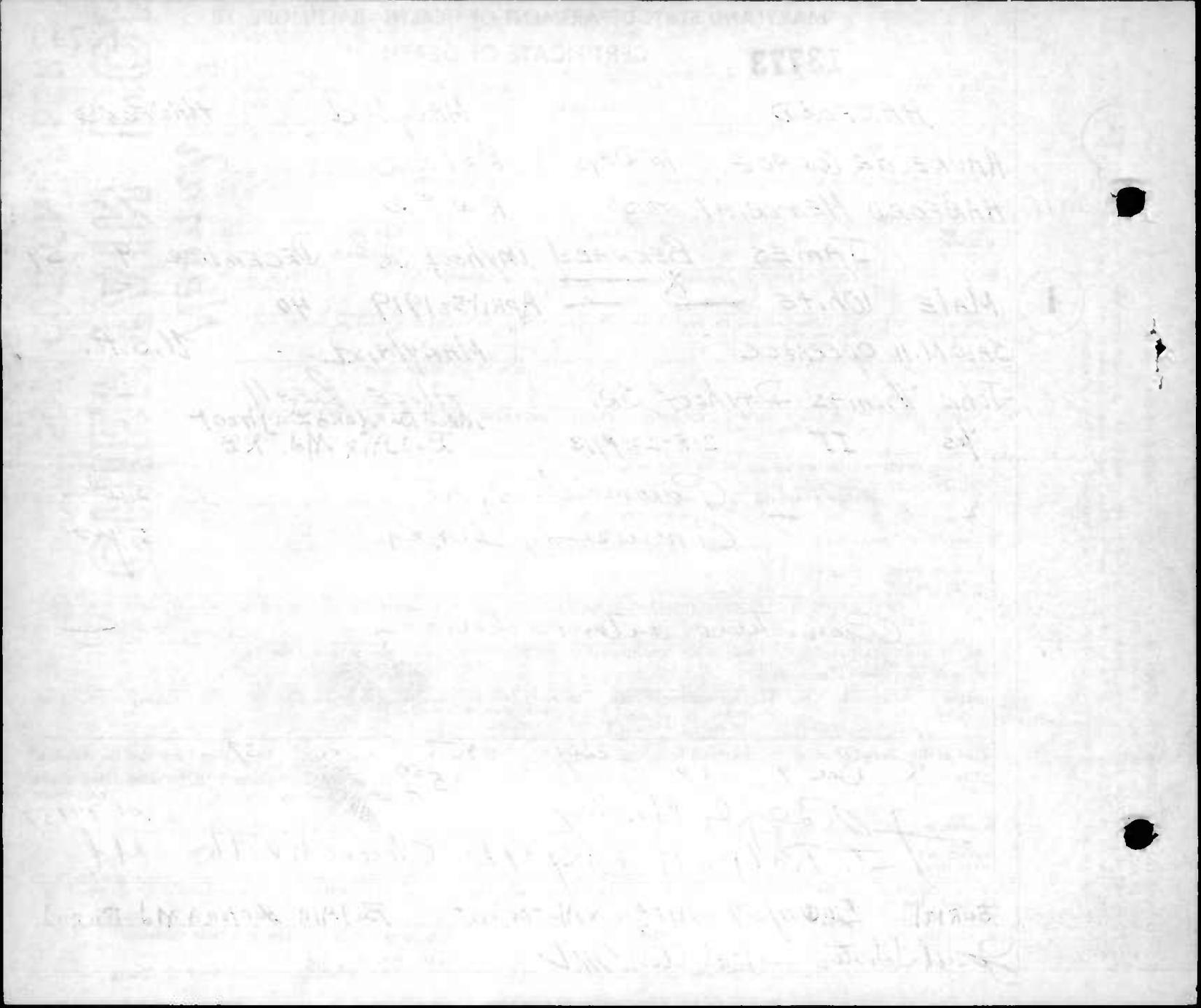
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

071

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												Reg. Dist. No. 13749	
13773 CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY HARFORD						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARVE DE GRACE						c. LENGTH OF STAY IN 1b 15 Days						b. COUNTY HARFORD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD Memorial Hosp.						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. STREET ADDRESS RD #2													
3. NAME OF DECEASED (Type or print) JAMES			First	Middle	Last	4. DATE OF DEATH DECEMBER 9 1959			Month	Day	Year		
5. SEX MALE			6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH APR 15 1919			9. AGE (In years lost birthday) 40 yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SAW MILL OPERATOR			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME John Thomas Dayhoff Sr.			14. MOTHER'S MAIDEN NAME Alice BEALL										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. 218-32-5713			INFORMANT Mrs. BERNARD Dayhoff			17. INTERVAL BETWEEN ONSET AND DEATH 2 weeks				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492 X <i>Pneumonitis, rt</i>			DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cirrhosis, liver</i>						5 yrs				
DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Premature arteriosclerosis												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)										
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19			20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) Bel Air		(County) Harford	(State) Md	
21. I certify that I attended the deceased from Aug 1955 to Dec 1959 , that I last saw the deceased alive on Dec 9, 1959 , and that death occurred at 550 A M, from the causes and on the date stated above.												DATE SIGNED Dec 9 1959	
ACTUAL SIGNATURE J. Ralph Horky MD			ADDRESS (Street, city or town, state) Churchville Md										
PHYSICIAN'S NAME (Type) J. Ralph Horky MD													
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			22b. DATE THEREOF Dec 11 59			22c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion Methodist			22d. LOCATION (City, town, or county) Bel Air			(State) Harford Md Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Foster			ADDRESS Bel Air Md			24a. REC'D BY REGISTRAR Dec 14 '59			24b. REGISTRAR'S SIGNATURE John S. Evans				
VS A15 (4) 15M 9/58													



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13750

Reg. Dist. No.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		13774										2			
13774		1. PLACE OF DEATH a. COUNTY HARFORD			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND			13750							
		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE			c. LENGTH OF STAY IN 1b 1 hr, 45 min.									c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TORT DEPOSIT , Rural	
071		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HARFORD MEMORIAL			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
		3. NAME OF DECEASED (Type or print) ROLAND WILLARD			First	Middle	4. DATE OF DEATH Downin Jr.	Month	Day	Year					
1		5. SEX MALE			6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH JUNE 1, 1944	9. AGE (In years last birthday) 15 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.				
		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT			10b. KIND OF BUSINESS OR INDUSTRY HIGH SCHOOL	11. BIRTHPLACE (State or foreign country) MARYLAND	Months		Days	Hours	Min.				
0		13. FATHER'S NAME ROLAND W. DOWNIN SR.			14. MOTHER'S MAIDEN NAME ROBERTA EBERHARDT			12. CITIZEN OF WHAT COUNTRY? U.S.A.							
		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. NONE	17. INFORMANT ROLAND DOWNIN SR.	Address (SAME)								
07		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 822X			BASAL SKULL FRACTURE C CONTUSION AND CONCUSSION BRAIN			INTERVAL BETWEEN ONSET AND DEATH 1hr 45min							
		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			DUE TO (c)										
2		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto Accident ROLLED AUTO OVER										
2		20c. TIME OF INJURY Month, Day, Year Hour 10/15 o.m. DEC 31 1959			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HIGHWAY	20f. (City or town) RISING SUN, CECIL MD	(County) CECIL	(State) MD						
		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
2		ACTUAL SIGNATURE Philip W. Heuman			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED DEC 31, 1959							
		EXAMINER'S NAME (Type) Philip W. Heuman MD.													
2		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-3-1960	22c. NAME OF CEMETERY OR CREMATORIAL West Nottingham Cem.	22d. LOCATION (City, town, or county) Colora, Md. Rural	(State) MD								
		23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son		ADDRESS Perryville, Md.	24a. REC'D BY REGISTRAR DATE JAN 4 '60	24b. REGISTRAR'S SIGNATURE Leanne S. Price									
VS. A15ME BM 2/57															

WISCONSIN STATE BOARD OF EXAMINERS OF HIGHER EDUCATION
MATERIAL EXAMINER'S CERTIFICATE OF DEAN

STATE BOARD
TREASURER

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13775

CERTIFICATE OF DEATH

Reg. Dist. No.

13751

TO HOSPITAL or ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Harford.		a. STATE <u>Md</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY <u>Harford</u>	
Harve-de-Grace		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. LENGTH OF STAY IN 1b 7 hrs.		d. STREET ADDRESS 24 Harve-de-Grace 1213 Union Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH December 20 19 59	
First <u>Robert</u> Middle <u>Luther</u> Last <u>Eggers</u>		Month Day Year	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>12-20-59</u>	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years lost birthday) yrs. <u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LUTHER EGERS</u>		14. MOTHER'S MAIDEN NAME <u>Renee SPRADLING</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>*** ***</u>	
17. INFORMANT <u>Luther Eggers</u>		Address <u>213 N. Union</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>768.0</u>		<u>Antepartum & intra partum</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		<u>uterine inertia</u>	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Havre de Grace</u> (County) <u>Md.</u> (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>12/20/59</u> , 19, to <u>12/20/59</u> , 19, that I last saw the deceased alive on <u>12/20/59</u> , 19, and that death occurred at <u>5:00 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>602 S. Union Ave.</u> DATE SIGNED <u>12/20/59</u>	
ACTUAL SIGNATURE <u>Richard Norment, M.D.</u>		M.D.	
PHYSICIAN'S NAME (Type) <u>Richard Norment, M.D.</u>		Havre de Grace, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/24/1959</u>	
22c. NAME OF CEMETERY OR CEMETORY <u>Grove Presbyterian</u>		22d. LOCATION (City, town, or county) <u>Aberdeen County (Md.)</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Sanning - Aberdeen Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>		24b. REGISTRAR'S SIGNATURE	
DATE <u>DEC 28 '59</u>			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13776 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13752

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Harford		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harriet Grace		c. LENGTH OF STAY IN 1b 25 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 24 Harriet Grace, Md	
3. NAME OF DECEASED (Type or print)		First	Middle
William C. Gerard			Last
4. DATE OF DEATH		Month	Day
December 26		Year	1959
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH
M		W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 6/1/1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Plumber		Kellog Contractor	Baltimore, Md.
13. FATHER'S NAME		14. MOTHER'S MARRIED NAME	
Frank G. Gerard		Pauline Chanc	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
		Unknown	Capitol Chanc 17 N. Univ Ave, Md
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
422.1		Anterior sclerotic CV disease	
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)	
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> Baltimore, Md DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 12-20-59	
22a. BURIAL/CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
12/23/59		22c. NAME OF CEMETERY OR CREMATORIAL Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Lemuel J. R. Harford, Md		24a. REC'D BY REGISTRAR Dated 29 '59	
24b. REGISTRAR'S SIGNATURE		Arthur S. Knapp	

BY THE MEDICAL STAFF OF DEAN'S HOSPITAL - BIRMINGHAM

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13787 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13753

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Mc Taylor</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Taylor</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Taylor</i>		c. LENGTH OF STAY IN 1b <i>4 Months</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Pocock Road</i>		e. STREET ADDRESS <i>114 Taylor Man</i>	
3. NAME OF DECEASED (Type or print) <i>James First Earl Middle Hamm</i>		4. DATE OF DEATH Month <i>Dec.</i> Day <i>12</i> Year <i>1959</i>	
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>4-9-31</i>	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years last birthday) <i>28 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm Labor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Gen. Farming</i>	
11. BIRTHPLACE (State or foreign country) <i>Ashe Co. Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Austin Hamm</i>		14. MOTHER'S MAIDEN NAME <i>Susan Caroline Taylor</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>325-34-2017</i>	
17. INFORMANT <i>Mrs. Mamie Lee Hamm, Monkton Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Compound, comminuted fracture skull with evulsion brain</i>		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO <i>812X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident, auto pedestrain type</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>12-11-59</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Pocock Road</i>		20f. (City or town) <i>Taylor</i> (County) <i>Bedford</i> (State) <i>Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Gerald E Palmer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Gerald E Palmer (u)</i>		DATE SIGNED <i>12-12-59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/15/1959</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Independence</i>		22d. LOCATION (City, town, or county) <i>Independence Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles E. Kurt, Jarrettsville, Md.</i>		24a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i>	
ADDRESS <i>Jarrettsville, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
DATE DEC 15 '59			

MISSOURI STATE BOARD OF HEALTH—DIVISION OF
MEDICAL EXAMINERS CERTIFICATE OF DEATH

1924-1925

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13754

1. PLACE OF DEATH a. COUNTY <i>Havre de Grace</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bel Air</i>		c. LENGTH OF STAY IN 1b <i>2 weeks</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>118 S. Main St.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>32 Bel Air</i>	
d. STREET ADDRESS <i>118 S. Main St.</i>		d. STREET ADDRESS <i>118 S. Main St.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Barbara</i>		First <i>Barbara</i>	Middle <i>Hawks</i>
4. DATE OF DEATH <i>December 22 1959</i>		Month <i>December</i>	Day <i>22</i>
5. SEX <i>F</i>		6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH <i>Jan. 2 1958</i>		9. AGE (In years last birthday) yrs. <i>11 13</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Havre de Grace Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Darwin Hawks</i>		14. MOTHER'S MAIDEN NAME <i>Nellie Bare</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Darwin Hawks Bel Air, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. <i>Dec 22 1959</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec 22, 1959</i> to <i>Dec 22, 1959</i> , that I last saw the deceased alive on <i>Dec 22, 1959</i> , and that death occurred at <i>10 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Gerald C Palmer</i> M.D.		ADDRESS (Street, city or town, state) <i>Bel Air, Md.</i> DATE SIGNED <i>12-22-59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-24-1959</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Oakgrove Cem.</i>		22d. LOCATION (City, town, or county) <i>Bel Air, Md.</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Vernon E. Muller Risingsun Md.</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 24 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 254 1-5-60 ams

13777

CERTIFICATE OF DEATH

Reg. Dist. No.

13755

1. PLACE OF DEATH a. COUNTY HARFORD		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HanoverGrace		c. LENGTH OF STAY IN 1b 31 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen N.	
3. NAME OF DECEASED (Type or print) Charles M. Johnson		d. STREET ADDRESS 13 Rogers, ST.	
4. DATE OF DEATH 12 18 1959		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 11, 1867	
9. AGE (In years from birth to death) 92 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Bank, & Insurance	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel M. Johnson		14. MOTHER'S MAIDEN NAME Caroline Nowland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-12-2975	
17. INFORMANT Theodore Cooke Long Bay Harbor (Deceased)		Address Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 XDUETOX Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			
Cardiac Failure; Atherosclerotic Heart Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) II Fracture, Left Femoral neck, (FEMUR)			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-17 , 19 59 , to 12-18 , 19 59 , that I last saw the deceased alive on 12-18 , 19 59 , and that death occurred at 7:35 PM , from the causes and on the date stated above. ACTUAL SIGNATURE Frank D. Hauber M.D. ADDRESS (Street, city or town, state) 608 South Union Ave., HanoverGrace DATE SIGNED 12/18/59			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 12/21/59	
22c. NAME OF CEMETERY OR CREMATORIAL North-East Cemetery		22d. LOCATION (City, town, or county) North East, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John D. Tarring		ADDRESS Tarring Funeral Home Aberdeen, Md.	
24a. REC'D BY REGISTRAR DATE DEC 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or cremation.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13778 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13757

1. PLACE OF DEATH a. COUNTY <i>Harford</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>	b. COUNTY <i>—</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hause de Grace</i>	c. LENGTH OF STAY IN 1b <i>—</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore 3V01-4</i>								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i>	d. STREET ADDRESS <i>411 Park Ave</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <i>Cecelia Eleanor Menger</i>	First <i>—</i>	Middle <i>—</i>	Last <i>—</i>	4. DATE OF DEATH <i>December 15 1959</i>	Month <i>—</i>	Day <i>—</i>	Year <i>—</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 24, 1890</i>	9. AGE (in years last birthday) <i>69 yrs.</i>	IF UNDER 1 YEAR Months <i>—</i>	IF UNDER 24 HRS. Days <i>—</i>	Hours <i>—</i>	Min. <i>—</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laundry work (ret'd)</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Lord Balto. Hotel</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>William Barry</i>			14. MOTHER'S MAIDEN NAME <i>Mary Bennett</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>217-03-2191</i>		17. INFORMANT <i>Mrs. Catherine Brannan, Joppa, Maryland</i>	Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Fracture skull</i>									INTERVAL BETWEEN ONSET AND DEATH <i>—</i>	
816 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) DUE TO <i>—</i>		(c) DUE TO <i>—</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident</i>								
20c. TIME OF INJURY Month, Day, Year Hour <i>7</i> p.m. <i>12-15 1959</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Auto. 40</i>		20f. (City or town) <i>Joppa</i>		(County) <i>Hart</i>	(State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Gerald C Palmer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Ed A. Jr.</i> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
EXAMINER'S NAME (Type) <i>Gerald C Palmer MD</i>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>12-19-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cemetery</i>		22d. LOCATION (City, town, or county) <i>Baltimore</i>			(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Cook, Inc., 1217 St. Paul Street</i>		ADDRESS							24a. REC'D BY REGISTRAR DATE <i>DEC 21 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

WISCONSIN STATE GOVERNMENT OF MUSKIE - HANNAH
POLITICAL EXAMINER'S CERTIFICATE OF DEATH

10000

10000

46-3101

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13756

1. PLACE OF DEATH a. COUNTY Harford		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hardey Trace		c. LENGTH OF STAY IN 1b c. STREET ADDRESS Liberty Grove 07X-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA H Harford Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert M. Moulton		4. DATE OF DEATH December 26	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 27, 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert M. Moulton Jr.		14. MOTHER'S MAIDEN NAME Stella Faye Wyatt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 17. INFORMANT Address Robert M. Moulton Jr., Liberty Grove, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> INTERVAL BETWEEN ONSET AND DEATH			
491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
Aspiration vomitus			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Gerald C Palmer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Gerald C Palmer, MD		DATE SIGNED Baltimore, Md 12-26-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-28-1959	
22c. NAME OF CEMETERY OR CREMATORIAL New Bridge Cemetery		22d. LOCATION (City, town, or county) (State) Colora, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Celia Patterson, Jr.		ADDRESS Perryville, Md	
24a. REC'D BY REGISTRAR DATE DEC 29 '59		24b. REGISTRAR'S SIGNATURE Celia S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be referred to by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the certificate should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 13789 CERTIFICATE OF DEATH 13758

Reg. Dist. No. _____

1. PLACE OF DEATH a. COUNTY <i>Harford</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Maryland</i> <i>Long Bay, Harford</i> LENGTH OF STAY IN lb <i>2 yrs.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Long Bay, Harford</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>		d. STREET ADDRESS <i>—</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Margaret M. Page</i>	First <i>M</i>	Middle <i>—</i>	Last <i>Page</i>	4. DATE OF DEATH <i>12/5/59</i>	Month <i>Dec</i> Day <i>5</i> Year <i>1959</i>
5. SEX <i>Female</i>	6. COLOR OF HAIR <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/30/1878</i>	9. AGE (In years, less birth day) <i>80</i> yrs.	IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> Months <i>—</i> Days <i>—</i> Hours <i>—</i> Min. <i>—</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>Md. Holly, D. C.</i>	
13. FATHER'S NAME <i>Master J. Brady</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Power</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Margaret M. Settinger, Neshannock, Pa</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332x</i> DUE TO <i>Generalized Circulatory Failure</i> INTERVAL BETWEEN ONSET AND DEATH <i>20 hours</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Cerebral Thrombosis</i> 17 days (c) DUE TO <i>Cerebral Arteriosclerosis</i> 5 yr.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>—</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) <i>—</i> (County) <i>—</i> (State) <i>—</i>	
21. I certify that I attended the deceased from <i>10-6-</i> , 19 <i>58</i> , to <i>12-5-</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>12-5-1959</i> , and that death occurred at <i>1:30 P.M.</i> from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Peter P. Rodman, M.D.</i>		M.D. <i>8</i>		ADDRESS (Street, city or town, state) <i>8 Laurel St., Aberdeen, Md.</i> DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>Peter P. Rodman, M.D.</i>					
22a. CEMETERY OR CREMATORIAL REMOVAL (Specify) <i>St. Mary's</i>		22b. DATE THEREOF <i>12/9/59</i>		22c. NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) <i>St. Mary's</i> (State) <i>—</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>—</i>		ADDRESS <i>—</i>		24a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i> DATE <i>DEC 10 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>—</i>					

CERTIFICATE OF DEATH

18188

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMA. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13790 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14367

1. PLACE OF DEATH

a. COUNTY

Harford

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Edgewood Rt. 40

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)

First
JEREMIAH

Middle
PATRICK

5. SEX

Male

6. COLOR OR RACE

C.

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

Oct. 12, 1934

9. AGE (in years
last birthday)

25
yrs.

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Plasterer

10b. KIND OF BUSINESS OR INDUSTRY

Home const.

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Sidney Patrick

14. MOTHER'S MAIDEN NAME

Della Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank, dates of service)

no

16. SOCIAL SECURITY NO.

250-54-3170

17. INFORMANT

Vernee Floyd

Address

Trenton, N.J.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Carbon monoxide poisoning

INTERVAL BETWEEN
ONSET AND DEATH

816X

DUE TO

and

second and third degree body burns

(b)

DUE TO

(c)

MEDICAL CERTIFICATION

20c. TIME OF INJURY Month, Day, Year

10:00 a.m. Dec. 25 1959

20d. INJURY OCCURRED

While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Highway

20f. (City or town)

Edgewood

(County)

Harford

(State)

Md.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

12/26/59

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

(State)

Conway Cem

Conway S. C.

23. FUNERAL DIRECTOR

ADDRESS

McKiernan Funeral Home

24a. REC'D BY REGISTRAR

DATE JAN 7 '60

24b. REGISTRAR'S SIGNATURE

Arthur S. Krause

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4, telephone call-Lassahn Funeral Home 12/24/59 c.a.c.

CERTIFICATE OF DEATH

Reg. Dist. No. 13759

1. PLACE OF DEATH a. COUNTY HARFORD		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) JOPPA MD		c. LENGTH OF STAY IN 1b 10 YEARS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RT. 1. Box 252A JOPPA MD.		e. STREET ADDRESS RT. 1. Box 252A JOPPA MD	
3. NAME OF DECEASED (Type or print) CHARLES		First WILLIAM	Middle RASPE
4. DATE OF DEATH December 17 1959.		Month December	Day 17
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH SEPT 17, 1889
8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 70 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY ARMY CHEM. CENTER.	
11. BIRTHPLACE (State or foreign country) MARYLAND.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN H RASPE JR.		14. MOTHER'S MAIDEN NAME MARGARET RAVADGE.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-03-8007	
17. INFORMANT Mrs CHARLES RASPE RT. 1. JOPPA Md.		Address Box 252A	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 180X		INTERVAL BETWEEN ONSET AND DEATH 12 months.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Renal tumor (left kidney) with metastasis to lung			
(b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-30 , 1954, to 12-17 , 1959, that I last saw the deceased alive on 12-16 , 1959, and that death occurred at 4:30 M, from the causes and on the date stated above. ACTUAL SIGNATURE Fred O. Hodous		ADDRESS (Street, city or town, state) Edgewater, Md. DATE SIGNED 12-18-59	
PHYSICIAN'S NAME (Type) Fred O. Hodous		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
22b. DATE THEREOF DEC 19, 1959.		22c. NAME OF CEMETERY OR CREMATORIUM VERUSALEM.	
22d. LOCATION (City, town, or county) JOPPA		(State) MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home 7401 Belair Rd		ADDRESS DATE REC'D BY REGISTRAR DEC 23 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

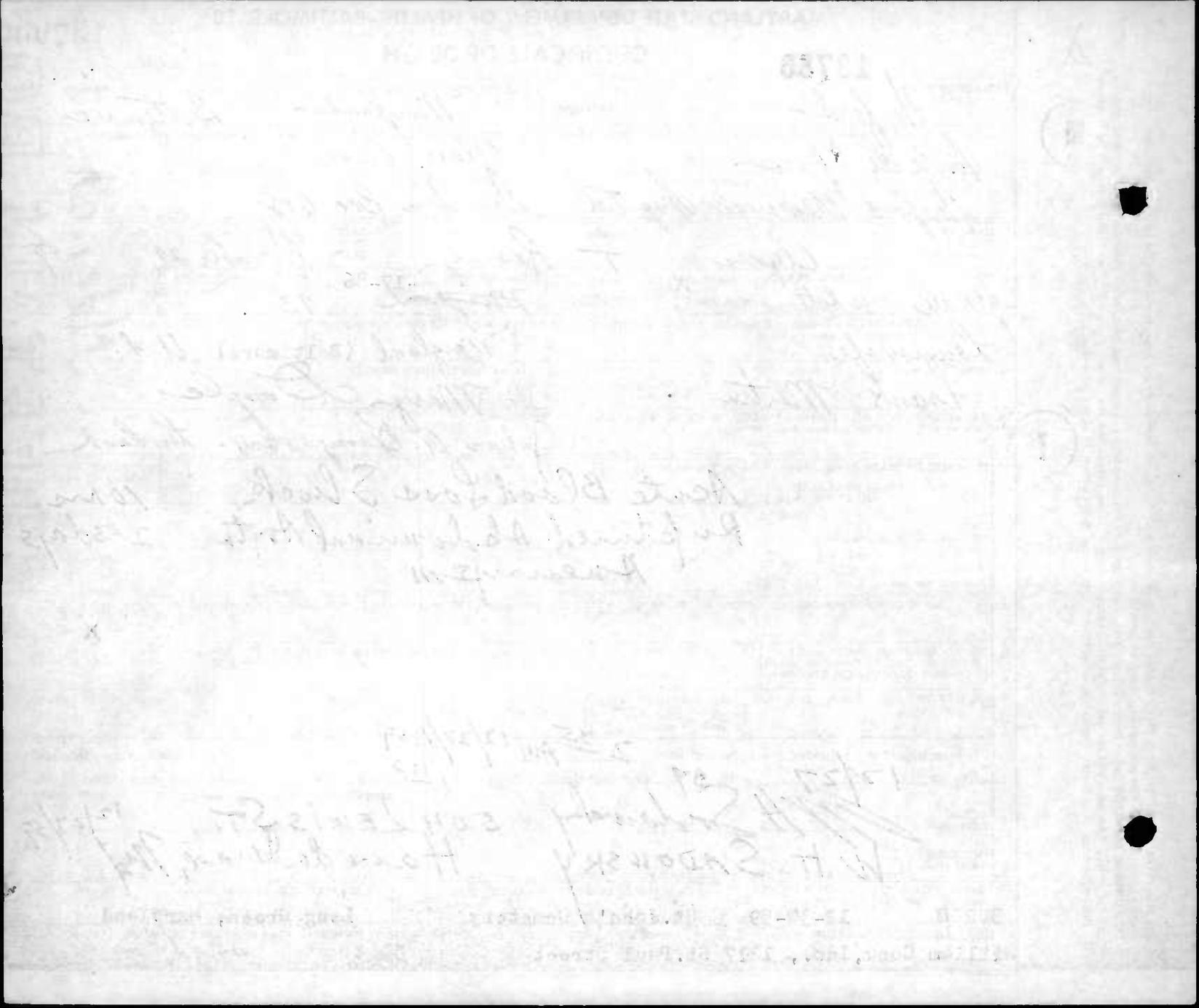
65373-1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13760

1		X		13780		CERTIFICATE OF DEATH			
TO HOSPITAL		TO ATTENDING PHYSICIAN		The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.		TO FUNERAL DIRECTOR		After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.	
M		071		dayford		MARYLAND		Baltimore	
1		18		a. PLACE OF DEATH a. COUNTY		b. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		a. STATE Maryland	
2		2		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
B		2		c. LENGTH OF STAY IN 1b		d. STREET ADDRESS		c. LENGTH OF STAY IN 1b	
13780		2		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
1		2		dayford Memorial hospital		Glen Arm Box 608		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3		3		3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		Month December 27, 1959	
4		4		First Agnes		Last Peaney		Day Year	
5		5		5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
6		6		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-17-86	
7		7		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 73 yrs.	
8		8		housewife		11. BIRTHPLACE (State or foreign country)		10. IF UNDER 1 YEAR Months Days Hours Min.	
9		9		13. FATHER'S NAME Frank Martin		Maryland (Baltimore)		11. CITIZEN OF WHAT COUNTRY? U. S.	
10		10		14. MOTHER'S MAIDEN NAME Mary Doyle		Address Julian A. Peaney - same - his band			
11		11		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
12		12		(If yes, give war or dates of service)		INFORMANT		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X	
13		13		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)		Acute Blood Loss Shock	
14		14		DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 10 hrs	
15		15		Ruptured Abdominal Aorta				2-3 days	
16		16		Aneurysm					
17		17		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
18		18		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) 35	
19		19		20f. (City or town) Baltimore		(County) (State)			
20		20		21. I certify that I attended the deceased from alive on 12/27/59, 1959, and that death occurred at 15P M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED 12/27/59	
21		21		ACTUAL SIGNATURE W.H. Sadowsky M.D. 504 LEWIS ST.					
22		22		PHYSICIAN'S NAME (Type) W.H. SADOWSKY		Hawde Grace, Md.			
23		23		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-30-59		22c. NAME OF CEMETRY OR CREMATORIY St. John's Cemetery	
24		24		22d. LOCATION (City, town, or county) Long Green, Maryland		(State)			
25		25		24a. REC'D BY REGISTRAR DEC 29 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thorne			
26		26		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		William Cook, Inc., 1217 St. Paul Street			
27		27		DATE					





TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any part is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14368

13792 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film 6254 1-13-60 et

1. PLACE OF DEATH a. COUNTY Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE New Jersey		b. COUNTY Mercy	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood Rt. 40		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 632 Princeton Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HENRY		First	Middle	4. DATE OF DEATH December 25 1959	Month	Day	Year
5. SEX Male		6. COLOR OR RACE C.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 24 1935	9. AGE (In years least birthday) 24 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dish Washer		10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Glennie Riggins		14. MOTHER'S MAIDEN NAME Alice Mc Cray		Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Vernee Floyd Trenton N.J.			
no		DUE TO Carbon Monoxide Poisoning and (b) second and third degree body burns		DUE TO (a) Auto-bus Accident (c)		INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Carbon Monoxide Poisoning 816X		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) Auto-bus Accident		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Highway		20c. TIME OF INJURY Month, Day, Year Hour a.m. 10:00 xxx Dec 25 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Edgewood Harford Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> Charles S. Petty		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D.		DATE SIGNED 12/26/59	
ACTUAL SIGNATURE Charles S. Petty		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county) Conway Cem Conway S.C.			
EXAMINER'S NAME (Type) Charles S. Petty		22a. BURIAL, CREMATION, REMOVAL (Specify) Conway		22b. DATE THEREOF 12-30-59		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mc Henry Funeral Home	
23. FUNERAL DIRECTOR Mc Henry Funeral Home		24e. REC'D BY REGISTRAR Arthur S. Kraus		24b. REGISTRAR'S SIGNATURE DATE JAN 7 '60			
1408 Race Path Ave., Conway, S.C.							

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THE BIRDS OF THE BAHAMAS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13793

CERTIFICATE OF DEATH

Reg. Dist. No. 13761

1. PLACE OF DEATH a. COUNTY <i>HARTFORD</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EMMORTON</i>		c. LENGTH OF STAY IN 1b <i>35 years</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Edgewood Rd. Box 381</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Emmorton</i>			
3. NAME OF DECEASED (Type or print) <i>Constance Poor</i>		First <i>Constance</i>	Middle <i>Stump</i>		
4. DATE OF DEATH <i>Dec. 13, 1959</i>	Last <i>Stump</i>	Month <i>Dec.</i>	Day <i>13</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 3, 1899</i>		
9. AGE (In years last birthday) <i>60</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>		
13. FATHER'S NAME <i>Henry W. Poor</i>	14. MOTHER'S MAIDEN NAME <i>Constance Brandon</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			
16. SOCIAL SECURITY NO. <i>218-22-1468</i>	17. INFORMANT <i>John W. Stump</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>150x</i> (b) DUE TO (c) <i>Carcinoma of esophagus. spreading to lung & mediastinum</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <i>10 months</i>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. p.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Bel Air, Md.</i>	(County) <i>Baltimore</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>April 1959</i> to <i>Dec. 13, 1959</i> , that I last saw the deceased alive on <i>Dec. 13, 1959</i> , and that death occurred at <i>11:50</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Bel Air, Maryland</i>					
DATE SIGNED <i>Charles Richardson, M.D.</i>					
ACTUAL SIGNATURE <i>Charles Richardson, M.D.</i>					
PHYSICIAN'S NAME (Type) <i>CHARLES Richardson, M.D.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Dec 15/59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Mary's Episcopal</i>	22d. LOCATION (City, town, or county) <i>Emmorton, Maryland</i>	(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph J. Foster</i>			24a. REC'D BY REGISTRAR DATE <i>DEC 16 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Charles S. Moore</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4
may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, Pages 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13781

CERTIFICATE OF DEATH

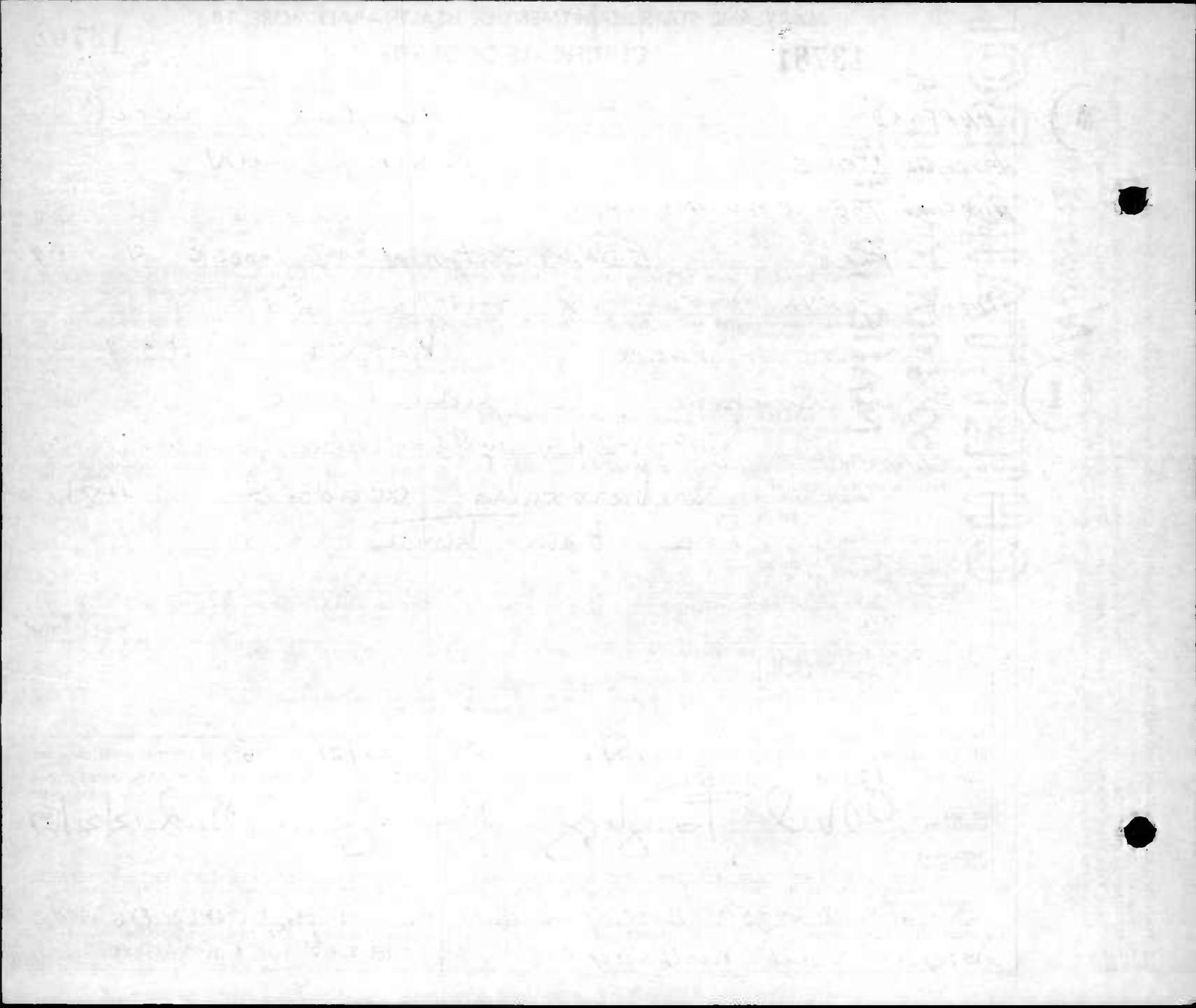
Reg. Dist. No.

13762

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY HARFORD		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAUPE DE GRACE		c. LENGTH OF STAY IN 1b		b. COUNTY CECIL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hospital		d. STREET ADDRESS Rising Sun 07X-2		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First FRED	Middle Edward Sutphin	Last EDWARD SUTPHIN	4. DATE OF DEATH DECEMBER 21 1959	Month Day Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-17-1905	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Ernest Sutphin		14. MOTHER'S MAIDEN NAME Lillie Kemp			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 218-07-6816		INFORMANT Harry & Ed Sutphin	
				Address Rising Sun, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 237X					
DUE TO Neurovascular accident					
INTERVAL BETWEEN ONSET AND DEATH 48 hrs					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Pos brain tumor					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Rising Sun	(County) (State) Md
21. I certify that I attended the deceased from 12/17 , 19 59 , to 12/21 , 19 59 that I last saw the deceased alive on 12/21 , 19 59 , and that death occurred at 3:50 AM , from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) Rising Sun, Md					
ACTUAL SIGNATURE Neil Tonge M.D.					
PHYSICIAN'S NAME (Type) Joseph P. Grant					
22a. BURIAL, CREMATION, REMOVAL Burial		22b. DATE THEREOF 12-24-59	22c. NAME OF CEMETERY OR CREMATORIAL North East Millwood	22d. LOCATION (City, town, or county) North East Millwood	(State) Md
23. FUNERAL DIRECTOR'S SIGNATURE Joseph P. Grant		ADDRESS North East Md	24a. REC'D BY REGISTRAR DATE DEC 28 '59	24b. REGISTRAR'S SIGNATURE Carlene S. Krause	



TO HOSPITAL **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled in with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13782

CERTIFICATE OF DEATH

Reg. Dist. No.

13763

1. PLACE OF DEATH a. COUNTY HARFORD		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE		c. LENGTH OF STAY IN 1b 15 HOURS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSP.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE 24	
3. NAME OF DECEASED (Type or print) BABY		First BABY	Middle GIRL
4. DATE OF DEATH DEC 20 1959		Last TUCKER	Month Day Year DEC 20 1959
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH DEC 20, 1959	
9. AGE (In years last birthday) one day		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEWBORN	
11. BIRTHPLACE (State or foreign country) HARFORD HOSP. MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES STERLING TUCKER		14. MOTHER'S MAIDEN NAME DOROTHY ANN CARLILE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT	
17. MEDICAL CERTIFICATION		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 20 , 1959, to Dec 21 , 1959, that I last saw the deceased alive on Dec 20 , 1959, and that death occurred at M. , from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) 114 W. Bel Air Ave	
ACTUAL SIGNATURE Andre Weiss M.D.		DATE SIGNED Aberdeen, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Henry R. Tucker Administrator		24a. REC'D BY REGISTRAR DATE DEC 29 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kuhn		25. LOCATION (City, town, or county) (State) Haure de Grace Maryland	
26. Cremation, Removal REMOVED		27. DATE THEREOF 12-20-59	
28. NAME OF CEMETERY OR CREMATORIUM HARFORD MEMORIAL HOSPITAL		29. ADDRESS 222 Seneca St	
30. ADDRESS 2071201X0		31. REC'D BY REGISTRAR DATE DEC 29 '59	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13783

CERTIFICATE OF DEATH

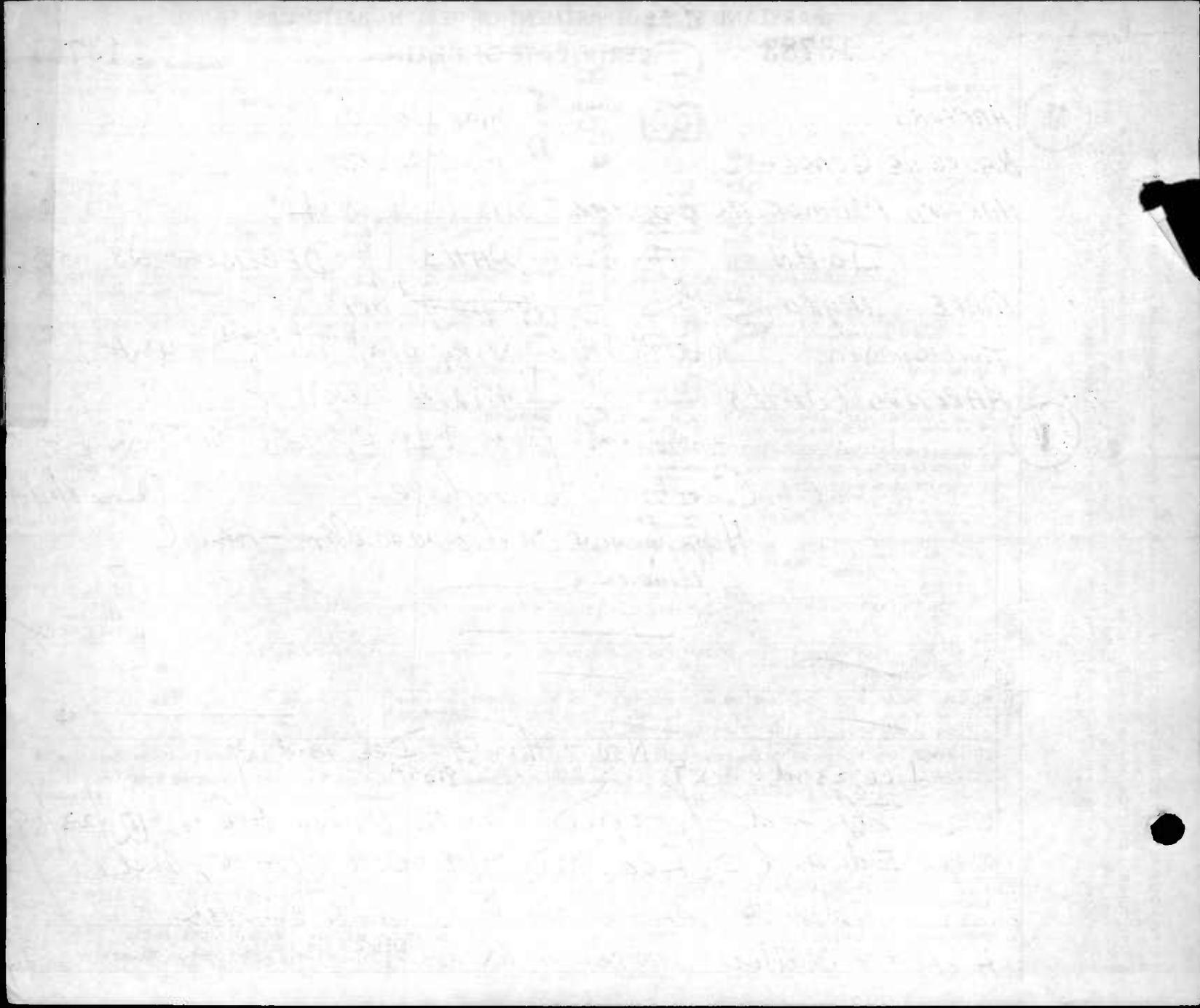
Reg. Dist. No.

13764

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY HARFORD		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN 1b		b. COUNTY Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3. VITAL RECORD NUMBER 3401-4	
3. NAME OF DECEASED (Type or print) John		First	Middle	Last	4. DATE OF DEATH DECEMBER 23 1959
5. SEX MALE		6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Aug 28 1904	9. AGE (In years lost birthday) 55 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Track Man		10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad		11. BIRTHPLACE (State or foreign country) Prince Edward County, Virginia	
13. FATHER'S NAME Harold Watts		14. MOTHER'S MAIDEN NAME Mildred Walker		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 705-10-3125		INFORMANT Mrs Ida S. Watts	Address 3117 Presbury St
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442 X		INTERVAL BETWEEN ONSET AND DEATH Since 11/20/59			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO		Cerebral Hemorrhage			
(c) DUE TO		Hypertensive Cardio-vascular - renal disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) (State) Prince Edward County, Virginia
21. I certify that I attended the deceased from Nov. 20th, 1959 to Dec. 23rd, 1959 that I last saw the deceased alive on Dec. 23rd, 1959 and that death occurred at 8:05 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 211 N. Union Ave.			
ACTUAL SIGNATURE Edward C. Foo, M.D.		DATE SIGNED 12/23/59			
PHYSICIAN'S NAME (Type) Edward C. Foo, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/28/59	22c. NAME OF CEMETERY OR CREMATORIAL Arbutus Mem. Park	22d. LOCATION (City, town, or county) Baltimore	(State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Herbert E. Shaffer		ADDRESS 3810 Bonner Rd	24a. REC'D BY REGISTRAR DEC 29 1959	24b. REGISTRAR'S SIGNATURE John S. Evans	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13765

13794

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARFORD		b. COUNTY HARFORD	
c. LENGTH OF STAY IN 1b 28 YEARS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARFORD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HOME.		d. STREET ADDRESS Box 1 Old Post Road	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LETTIE		First Ruth	Middle ZELLMAN
4. DATE OF DEATH DECEMBER 22 1959	Month	Day	Year
5. SEX F		6. COLOR OR RACE WH	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH FEB 14, 1914	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (In years lost birthday) 45 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITRESS	
11. BIRTHPLACE (State or foreign country) Virginia.		10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT	
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME ROBERT G. HALL.	
14. MOTHER'S MAIDEN NAME Laura B. Roberts.		15. SOCIAL SECURITY NO. 123-45-6789	
16. INFORMANT FREDERICK A. ZELLMAN. SAME. NO		17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) multiple pulmonary emboli DUE TO 171X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Carcinoma of Cervix - with widespread metastases. DUE TO (c) malnutrition.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 15 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) malnutrition.		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 15, 1959 , to December 22, 1959 that I last saw the deceased alive on December 18, 1959 , and that death occurred at 2:45 PM , from the causes and on the date stated above.		20f. ADDRESS (Street, city or town, state) 200 N. Union Street, Harford Co., MD	
ACTUAL SIGNATURE Raymond J. Donovan, Jr.		DATE SIGNED Dec 22 1959	
PHYSICIAN'S NAME (Type) Raymond J. Donovan, Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC 26 1959	
22c. NAME OF CEMETERY OR CREMATORIAL Rock Run		22d. LOCATION (City, town, or county) HARFORD Co., MD	
23. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell Harford Grace, Md.		24a. REC'D BY REGISTRAR DATE DEC 28 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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